STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
155694		B. WIN	G		10/10/2	2012	
NAME OF P	ROVIDER OR SUPPLIER	<b>\</b>			ADDRESS, CITY, STATE, ZIP CODE		
DET7 NII	IRSING HOME			116 BE	TZ RD N, IN 46706		
					IN, IIN 40700		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
F0000	REGUESTION ON			1710			DATE
	This visit was fo	or the Investigation of	F00	00			
	Complaint IN00	116203.					
	Complaint IN00	116203 - Substantiated.					
	Federal/state def	ficiencies related to the					
	allegations are ci	ited at F323.					
	Survey dates: O	ctober 9-10, 2012					
	Facility number:						
	Provider number						
	AIM number: 1	100273860					
	Survey team: He	oney Kuhn, RN					
	Census bed type						
	SNF/NF: 99						
	NCC: 5						
	Total: 104						
	Census payor typ	pe:					
	Medicare: 13						
	Medicaid: 60						
	Other: 31						
	Total 104						
	Sample: 4						
	•						
	This deficiency i	reflects state findings					
		nce with 410 IAC 16.2.					
	Quality ravian a	completed on October 15,					
	2012 by Bev Fat	•					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000306

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155694		(X2) MULTIPLE CC	00 		LETED 0/2012			
		100034	B. WING	ADDRESS OFFI STATE STO		// <u>C</u> U   <u>C</u>		
	ROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE  116 BETZ RD					
BETZ NU	IRSING HOME		AUBUR	RN, IN 46706				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		

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Event ID: 2GGU11

Facility ID: 000306

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	COMPLETED	
	155694		B. WIN		<del></del>	10/10/	2012	
			Б. WПV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER			116 BE				
BET7 NI	IRSING HOME				RN, IN 46706			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0323	483.25(h)	ENT						
SS=E	FREE OF ACCID	ENT ERVISION/DEVICES						
		ensure that the resident						
		ains as free of accident						
		sible; and each resident						
	· ·	e supervision and						
	assistance device	es to prevent accidents.						
	Based on observ	ation, record review, and	F03	23	F323 Free of Accident		10/26/2012	
	interview, the fac	cility failed to ensure			Hazards/Supervision/Devices	5		
	residents requirii	ng transfer with			Residents affected by the			
	•	ver) lifts were provided			alleged deficient practice;	_		
	` •	of two assistants during			<ul> <li>Twelve of twelve residents requiring two assists with</li> </ul>	5		
	•	ess. This had the			mechanical (Hoyer) lift			
	•	et 12 of 12 residents			transfers were found to hav	e		
	_				the potential to be affected by	the		
		ts with mechanical lifts			alleged deficiency.			
	_	Central Unit. (Residents:			Staff are using two persor			
		F", "G", "H", "J", "K",			assist with all mechanical (Hoy	/er)		
	"M", "N", "P", a	nd "Q")			lift transfers.  2. All residents requiring two			
					assists with mechanical (Hoye	r)		
	Findings include	c.			lift transfers are at risk to be	• /		
					affected by the alleged deficier	nt		
	During the initia	l tour, on 10/09/12			practice.			
	•	.m. and 12:30 p.m., LPN			Nursing staff have signed	l		
		CNA worksheets (a tool			the Mechanical Lift skills			
	•	`			validation acknowledging that they are aware of the need to			
	1	resident's care needs) for			have two staff persons at all			
		and indicated the			times when using a mechanica	al		
		current. The worksheets			lift.			
		9 residents, who resided			<ul> <li>A staffing analysis has be</li> </ul>	en		
		nit, required Hoyer (a			completed by the Director of			
	_	device to assist staff			Nursing Services and Assistan			
	residents betwee	n bed, chair, and			Director of Nursing Services an approved by the Executive	iu		
	wheelchair surfa	ces) transfers. The CNA			Director to identify staffing nee	ds		
		eated Residents "B", "C",			and appropriate utilization of	<del>-</del>		
		H", "J", "K", "M", "N",			patient per day (PPD) hours.			
	, _ , _ , _ , _	-, -,,, , , ,			Critical staffing with interventio	ns		
					i .			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETI			ETED	
		155694	B. WING 10/10/2012			2012	
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		116 BE			
BET7 NI	IRSING HOME				RN, IN 46706		
BETZ NURSING HOME		1		1			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	has also been identified.		DATE
		der "Mobility/Transfer			Residents requiring		
	Aids" as "A2 (A	ssist 2)-Hoyer".			mechanical (Hoyer) lift transfe	rs	
					will be evaluated by therapy to		
	1. The record of	Resident "C" was			determine if mechanical transf		
	reviewed on 10/	10/12 at 9:20 a.m.			is appropriate.		
	Resident "C" wa	as admitted to the facility			3. Systems to ensure alleged		
		h diagnoses including, but			deficient practice does not rec  A weekly HR meeting will		
		IS (multiple sclerosis),			conducted with the ED, DNS a		
		d history of falls. Review			scheduler to determine staffing		
		MDS (Minimum Data			patterns and staffing needs.	-	
		sist staff in determining			<ul> <li>Nursing personnel will be</li> </ul>		
		ed 07/20/12, indicated the			in-serviced by the Staff		
	· · · · · · · · · · · · · · · · · · ·	*			Development Coordinator by 10/26/12 on the Mechanical Li	f	
	resident was cog	milivery miaci.			skills validation to assure two	11	
	D : 0.1 W				persons and appropriate		
		Functional Status" of the			technique is utilized.		
		Resident "C" required			· Charge nurse will make		
	extensive assista	ance and 2 or more person			rounds every shift and docume		
	physical assist for	or transfer between			on a Nursing Rounds Form for residents requiring mechanica		
	surfaces including	ng to or from: bed, chair,			(Hoyer) lift transfers to assure		
	and wheelchair.				people and appropriate technic		
					are utilized when transferring		
	Review of a Car	e Plan for ADL's			a mechanical lift.		
	(Activities of Da	nily Living), dated					
	,	ted: "Assist with transfers					
	as needed."						
	do nocaca.				4. Monitoring to ensure alleged	d	
	Resident "C" wa	as identified on the initial			deficient practice does not rec	ur;	
		vable. Resident "C" was			DNS and/or designee will		
					complete the Mechanical Lift		
		10/10/12 at 9:30 a.m., and			Transfers CQI to ensure two persons and appropriate		
	indicated she ha				technique are utilized for resid	ent	
		1 assist with the Hoyer			safety when transferring reside		
		C" indicated the transfers			with a mechanical lift. CQI forr		
	had occurred mo	ore than 2 times but less			will be completed weekly x 4,		
	than 5 times.				monthly x 3, and then quarterly	y	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DITE	LDING	00	COMPLI	ETED	
		155694	A. BUI. B. WIN			10/10/2	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	₹		116 BE			
DET7 NII	JRSING HOME				N, IN 46706		
DETZINU	IKSING HOWE			AUBUR	in, in 46706		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	The DNS (Direct interviewed on 1 The DNS indicated Resident "C" we being updated to for ADL's.  2. The record of reviewed on 10/Resident "B" was on 08/16/90 with not limited to, A and adult FTT (Belieview of the mooth of the m	tor Nursing Services) was 10/10/12 at 11:40 a.m. ted the care plans for the being in process of the better reflect care needs of the better reflect care needs and 10/12 at 9:45 a.m. as admitted to the facility of diagnoses including, but alzheimer's, hypertension, Failure to Thrive).  Host recent MDS, dated ted the resident was not easy of the "Functional DS indicated Resident dependent and required 2 assist for transfer between the plan for ADL's, dated ted the resident required 2 assist for transfer between the plan for ADL's, dated ted the resident required all transfers." Review of a all Risk, dated 08/24/11,		TAG	thereafter to monitor. Findings be brought to the CQI committ monthly then quarterly with tracking and trending discusse If CQI reveals below the 90% threshold an action plan will be implemented.  5. Date of Completion: 10/26/1	ee ed. e	DATE
		ident required "Hoyer lift					
	for transfers"	nacht required Troyer fift					
	ior transfers"						
	survey, indicated	ff interviews, during the d Resident "B" had been one assist by direct care					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		r í	ATE SURVEY MPLETED	
AND PLAN	155694		A. BUILDING	00		10/2012
		103094	B. WING			10/2012
NAME OF I	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP	CODE	
DET7 NI	JRSING HOME		116 BE	12 RD RN, IN 46706		
			AUBUR	KIN, IIN 40700		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG	ì ·	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
TAG		LESC IDENTIFTING INFORMATION)	IAG	BENEIENCTY		DATE
	staff.					
	2 71 1	CD 11 (UEU				
		f Resident "E" was				
		10/12 at 11:10 a.m.				
		s admitted to the facility				
		n diagnoses including, but				
	not limited to, de	·				
	`	art Failure), osteoarthritis,				
		, and PVD (Peripheral				
	Vascular Disease	e).				
		ost recent MDS, dated				
	· ·	ted the resident was not				
	•	w of the "Functional				
	Status" of the M	DS indicated Resident				
	"E" was totally o	dependent and required 2				
	or more assist fo	r transfers.				
	Review of a Car	e Plan for ADL's, dated				
	06/22/11, indica	ted, "Hoyer lift to be used				
	for all transfers.'	' Review of a Care Plan				
	for Fall Risks, da	ated 06//22/11, indicated,				
	"Hoyer lift to be	used for all transfers."				
	Resident "W" w	as identified by staff as				
	interviewable. F	Resident "W" was				
	interviewed on 1	0/10/12 at 11:30 a.m.				
	Resident "W" is	the roommate of				
	Resident "E." F	Resident "W" indicated				
	regarding Reside	ent "E" : "is an invalid.				
	1	have two to move her but				
l	sometimes only					
	<b>[</b>					
	4. Resident "X"	was identified by staff as				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155694		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPI 10/10	LETED	
NAME OF PROVIDER OR SUPPLIER BETZ NURSING HOME			B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE TZ RD N, IN 46706	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Resident "X" is a "F". Resident "X had been recently assist with the H "X" indicated: ". lift her."  5. Confidential seconducted, through 10/09/12 at 12:0 11: 50 p.m. Tho RN's, LPN's, and worked all 3 shift confirmed all 12 Central Unit had been transferred two. All CNA' residents requiring to have 2 assists the staffing sche DNS (Director Normal Unit to be day and evening night shift. Interface frequently procall-offs not replayed or 2 CNAs on the for 56 residents asservices.	desident "X" was 0/10/12 at 11:45 a.m. the roommate of Resident X" indicated Resident "F" by transferred with one over recently. Resident and sometimes they just that interviews were ghout the survey between 0 p.m. and 10/10/12 at see interviewed included 111 CNAs who had its. The interviews residents residing on the at one time or another with one assist instead of interviewed indicated ing Hoyer transfers were at all times. Review of dule, provided by the dursing Services) tial tour, indicated the se staffed with 4 CNAs on shift and 2 CNAs on views indicated CNA's alled to other units or acced, resulting in only 1 in the unit with the capacity to receive care and incided thought and in the capacity to receive care and incided thought as a contract of the capacity to receive care and incided thought at the capacity to receive care and incided thought as a contract of the capacity to receive care and incided thought as a contract of the capacity to receive care and incided thought as a contract of the capacity to receive care and incided the capacity to the					

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Event ID: 2GGU11

Facility ID: 000306

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155694			LDING	NSTRUCTION  00	(X3) DATE COMP: 10/10		
NAME OF PROVIDER OR SUPPLIER  BETZ NURSING HOME			B. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE FZ RD N, IN 46706	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
	transfers for residuations.  CNA #6 indicated transfers on the Cassistance. CNA the only CNA at CNA #7 indicated residents by self CNA #7 indicated for assistance, but medications unait phone speaking to indicated staff is when residents higher transfers on the Cassistance of the CNA #8 indicated transfers on the Cassistance.  CNA #9 indicated transfers on the Cassistance.	dents on the Central Unit tee. CNA #5 indicated s pulled from unit to unit ted in CNA #5 working  and has provided Hoyer Central Unit without #6 indicated working as times.  and has transferred with the Hoyer lift. and has asked nursing staff at they cannot leave teended or are on the to physicians. CNA #7 not always available ave been sitting up for a me and need to be  and has provided Hoyer Central Unit without			CROSS-REFERENCED TO THE APPRI		
	because help has units. CNA #9 i of Hoyer transfe needs, cannot wa	with the Hoyer lift been pulled between indicated due to volume residents and acuity it for assistance when a in incontinent or sitting up in of time.					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155694		A. BUILDING COMPLETED		
155694			B. WING		10/10/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
BET7 NI	JRSING HOME		116 BE	N, IN 46706	
		ETATEMENT OF DEFICIENCIES		T	(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	CNA #11 indica alone due to cal resulting in one residents. CNA get CNA from a resident's need to incontinence is resident with or available.  The Director of interview on 10 indicated reside transfers are to incontinuous continuous continuou	atted frequently has worked al-offs (staff calling in ill), assist transfer of a #11 indicated attempts to other halls but due to to be returned to bed or sues, has to transfer are assist before help is a Nursing Services during 10/12 at 11:40 a.m., ants who require Hoyer be 2 person assists.  By relates to Complaint #			

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